Pediatric Alliance, PC

Pat ID:

Patient Information

Patient First Name	Patient Last Name	MI	Birthdate	Gender	Patient Social Security #

Patient Address	City	State	Zip	Phone

Guarantor Information

Guarantor First Name	Guarantor Last Name	MI	Birthdate	Guarantor Social Security #

Guarantor Address	City	State	Zip	Phone

Employer	Main Work Phone	Direct Work Phone

Emergency Contact Information (preferably someone outside the home)

First Name	Last Name	Relationship to Patient	Phone

Primary Insurance Information

Insurance Carrier Name	Policyholder First Name	Policyholder Last Name	Birthdate

Policyholder Address	City	State	Zip	Phone

Policy Number	Group Number	Co-pay Amount	Effective Date

Secondary Insurance Information

Insurance Carrier Name	Policyholder First Name	Policyholder Last Name	Birthdate

Policyholder Address	City	State	Zip	Phone

Policy Number	Group Number	Co-pay Amount	Effective Date

Authorization for Treatment

I request that payment of authorized benefits be made either to me or on my behalf to Pediatric Alliance, PC for services furnished by a physician of the corporation. I authorize release of medical information to the indicated insurance carrier in order to determine payment for related services.

Parent/Legal Guardian Signature: ________________________________ Date: _____________